Occupational Exposures of Reproductive, Developmental, or Breastfeeding Concern

Supervisor's Statement

To be completed by the supervisor for any worker with concerns regarding or potential exposure to workplace reproductive or developmental hazards, including those related to breastfeeding. This form should then be forwarded to appropriate medical personnel (Occupational Medicine or other healthcare provider). Please attach safety data sheets (SDS) for any substances to which this worker is exposed.

PLEASE PRINT

Worker _____ _____ _____ _____
Last name *First name* *M.I.* *DoD ID*

Rank/Rate/ Job Code _____ Today's date ____ ____ ____ ____ ____ ____ ____ ____
Day *Month* *Year*

1) Supervisor Name (Last, First, MI): _____
2) Supervisor Phone: _____ Supervisor Email: _____
3) Command Name/Code/Shop: _____
4) Worker's Job Duties (NOT Job Title/Position): _____
5) Workplace (check all that apply): ☐ Shipboard ☐ Shop ☐ Office ☐ Outdoors ☐ Other: _____
6) Is the worker exposed to any of the following hazards (check all boxes that apply)?:

Animal danders ☐	Microwave and other radio-frequency (RF) energy ☐	Strenuous work ☐
Bacteria ☐		Thermal stress (heat or cold) ☐
Endotoxins ☐	Mold or fungi overgrowth ☐	Vibration ☐
Enzymes and other proteins ☐	Noise ☐	Viruses ☐
Inorganic chemicals ☐	Organic solvents and fuels ☐	Other hazard (specify below) ☐
Ionizing radiation ☐	Pesticides (specify below) ☐	None ☐
Metals (lead, cadmium, etc.) ☐	Pharmaceuticals/drugs (specify below) ☐	

_____

_____

7) Personal Protective Equipment: ☐ None ☐ Ear plugs/muffs ☐ Glasses/goggles ☐ Gloves ☐ Helmet ☐ Respirator
8) Is the worker required to work shifts? ☐ No ☐ Yes (describe:)

_____

9) Is the worker in any medical surveillance program(s)? ☐ No ☐ Don't know ☐ Yes (list:)

_____

_____

10) Has the worksite had an Industrial Hygiene (IH) survey in the last 2 years? ☐ No ☐ Don't know ☐ Yes (date): _____
11) Are there IH sampling data for the worker? ☐ No ☐ Yes
12) Did the IH survey reveal reproductive or developmental hazards? ☐ No ☐ Yes (specify:)

_____

_____

13) Has the worker reported an occupational illness or injury in the past year? ☐ No ☐ Yes (specify:)

_____

14) Has a detailed evaluation of the worksite(s) and/or process(es) with which the worker is involved been performed?
☐ No ☐ Yes
15) Supervisor's signature: _____ Date: _____

Below this line for Medical Department use only

REVIEWING PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or handwritten entries, give: Name – last, first, middle, DoDID, Gender, Date of Birth, Rank/Grade.)*	MEDICAL FACILITY	STATUS
	DEPARTMENT/SERVICE / RANK/GRADE	DATE OF BIRTH
NAME:	SPONSOR'S NAME	DoD ID
DOB:	RELATIONSHIP TO SPONSOR	RECORD MAINTAINED AT:
DoD ID:		